A program undertaken to prepare clergymen to identify and help emotionally and mentally ill people is described. This is part of a larger program of mental health training for nonpsychiatric professionals.

MENTAL HEALTH TRAINING FOR MINISTERS

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Introduction

THE Bradley Center, Inc., a private, nonprofit, foundation-sponsored, outpatient psychiatric clinic in Columbus, Ga., has been engaged in developing and demonstrating a standardized, goal-limited program of mental health training for nonpsychiatric professionals. This program, of nine years duration, is based upon the common sense point of view that problems of emotional, mental, and social maladjustment are the legitimate concern and responsibility of many groups of professional workers in addition to the mental health disciplines and upon the obvious and gross shortage of mental health services outside of a few major metropolitan areas. Our training goals have been to provide nonpsychiatric professionals with the skills, concepts, and tools to enhance their existing mental health functions.

Our Operational Definition of Mental Health Training

The essential and basic mental health skills upon which we have focused are as follows:

1. A point of view about human behavior and functioning which permits the professional person to comprehend the social and psychological dimensions of the individual.

2. A standardized method for gathering comprehensive information about the individual's past and present functioning, his problems and complaints; and his resources and aspirations in the limited time available.

3. A systematic method of organizing, summarizing, and evaluating this data so that problems and resources are identified in a clear, meaningful manner.

4. A direct, and practical approach to planning for the use of the existing skill of the professional person and the skills of other available professionals to meet the needs of troubled people.

It is apparent that our scope of training is limited. Much of the curriculum of other mental health training programs is absent. There is, for example, no training in psychodiagnosis, psychopathology, psychotherapy, or personality theory. Only a limited amount of training in interviewing technics and counseling methods is included in our training in case management methods. It is our intent to reach large numbers of nonpsychiatrically trained, responsible professional people, offer them short periods of training in methods and approaches which may be incorporated into their everyday practice to enhance their existing mental health counseling function. Those professionals who wish, or require more specialized training are encouraged to seek it at appropriate training centers.

We would, in effect, be perfectly content to train 100 professionals who experience a 10 per cent improvement in their effectiveness, while other trainers are able to use an equivalent amount of time to bring about a 100 per cent improvement in the skills of ten persons.

Training of Ministers

The Bradley Center is now completing a three-year demonstration of our training methods for physicians and ministers,* and is beginning a new five-year training program† in which we will extend our training to larger numbers of physicians, ministers, nurses, caseworkers, and others. While detailed reporting of the results of our project is in preparation, our experiences in training ministers have been sufficiently distinctive and rewarding to merit separate consideration at this time.

A crude, composite picture of the average minister as we saw him may be drawn as follows: (1) he lives a tense, busy life weighted down with responsibilities for conducting religious services, preparing sermons, attending innumerable church functions and committee meetings, and carrying out educational and administrative duties; (2) he has a formal commitment to participate in both the happy and sad experiences in the life of his parishioners, weddings, confirmations, illness, death; (3) when faced with the less formalized conflicts and crises of life such as marital and family discord, emotional suffering, alcoholism, occupational failures and floundering, he feels both a sense of responsibility and a sense of inadequacy. Not having the time to identify problems at an early stage and take preventive action, he finds himself called upon to help in acute emergencies and responds often without fully understanding the situation.

It is our belief that at least a significant portion of the minister's dilemma can be dealt with if he possesses the following skills which are encompassed in our training:

A Point of View Regarding Human Behavior—Every acute human crisis has its origin in the past and present history of the individual. The more we know of his experiences, his successes, and failures in various life roles and functions, the better are we able to guide and counsel him in an adequate manner. We focus upon eight key life role areas: (1) relationship with father, (2) relationship with mother, (3) school experiences, (4) occupation, (5) marriage, (6) parenthood, (7) religion, (8) social and recreational activities. A knowledge of these past and present roles prevents a narrow focus upon the immediate complaints and tends to emphasize the complex, three-dimensional nature of human experiences. It has also been found essential to obtain a view of the inner emotional state of the individual. Since we did not wish to enter the maze of psychodiagnosis and psychopathology, we focus upon (9) emotional distress. This refers to symptoms of emotional discomfort and suffering which are assessed in a quantitative rather than a qualitative manner. We liken our summary and rating of emotional distress to the use of a thermometer. A nonmedical person may use the thermometer to determine the presence of fever. If the temperature is elevated, he knows that it is necessary to consult a physician without having to know the precise nature of the illness. A last role, (10) physical complaints, is used to focus attention upon physical conditions which may require medical attention or which may be pertinent to the individual's adjustment.

A Systematic and Time Saving Method for Collecting Personal Data—Compre-

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hensive information about the individual is essential if one is to use good judgment in problem identification and management. Collecting this information through conventional interview technics is very time-consuming and requires specialized training. A substitute for much of the lengthy interviewing procedures has been developed in a set of self-administered materials which we call the Personal Data Kit. It consists of: (1) a Biographical Review answered in essay form; (2) an Information Check List which parallels the Biographical Review, but requires only checks, underlining, and ratings for responses; (3) the Mooney Problem Check List; and (4) the Cornell Index. The use of the kit at an early point in the helping relationship apparently contributes, in many cases, to greater frankness and openness in communications.

A Meaningful Method for Summarizing Information, Pinpointing Problems and Resources, and Planning a Remedial Program—The availability of information about an individual may avert the sin of oversimplification, but may not prevent floundering unless this information can be organized and used in a meaningful manner. The heart of our training program is focused upon organizing, summarizing, evaluating, and using this information to identify areas of strength and weakness and to plan a remedial program. Using a three-page "Summary and Planning Guide," the minister is taught to first summarize information pertinent to each of the ten categories (the eight role areas, emotional distress, and physical complaints). Judgments, in the form of ratings, are made about the adequacy of functioning in each area. The third page of this form is used to summarize in an organized manner the problems and liabilities and the resources and assets which have been identified. Based upon the individual's needs the minister formulates a tentative plan for helping. He is to plan how he may use his own skills, as well as the skills of other professions and agencies to provide assistance. Training is conducted in 12 weekly two-hour sessions. The trainees bring their own case materials for group consideration. As many as 30 cases have been discussed in a workshop period. Additional consultation time is available during and after the course.

Significance of this Training Program

In our view, the training program we have outlined has the following merits:

1. It constitutes a standardized, "package" training program which can be taught to ministers and other responsible professional people in their own community and in a limited amount of time.
2. It is a significant saver of the scarce counseling time of the ministers. The entire process of summarizing, rating, and tentative planning may be completed in 30 minutes or less after proper training.
3. This "package" of training methods can be taught to responsible educators and trainers in a relatively short time. We have, for example, trained pastoral counselors, psychiatrists, and psychologists who are now training ministers in various parts of the United States and Canada.
4. It facilitates consultations with other resource personnel. With the completed "Guide" as a written outline of pertinent information, a useful case consultation may be completed in 30 minutes or less. Emergency consultations, in person or by telephone, have been completed in ten minutes.
5. The methods and point of view taught do not entail changes in professional function, identification, or ideology.

Results of Training

The results which can be presented now are essentially impressionistic and

will be subjected to careful scrutiny under the more objective control of a sociologist who has been working along with us.

The first and most striking impression we obtained is of eager responsiveness of ministers to this type of training. During an 18-month period in two demonstration communities, we trained 32 ministers in Community A and 22 in Community B. These totals represent over 70 per cent of the communities' ministers. The task of obtaining recruits for each new workshop was undertaken, for the most part, by the county ministerial alliance. Attendance at workshop sessions was quite high and the "drop-out" rate unusually low.

A second striking result noted was the large number of ministers who could be trained by a small staff. The project staff was able to provide the following time: psychologist (project director), three days per week; psychiatrist (co-director), one day per week; pastoral consultant, full-time. This small staff trained a total of 127 ministers in six different communities. Four of the communities were located at distances ranging from 47 miles to 180 miles and thus entailed the use of much time for travel. The staff time was further limited by the necessity of planning carefully for each new step, reporting the results of workshop experiences, planning, conducting, and gathering data for the various evaluation studies, and also simultaneously conducting training for groups of physicians.

During the course of training the following distinct trends were noted: (1) increased counseling activities by the minister; (2) an initial uncovering of long neglected severe problems which often required rapid referral; (3) a subsequent focusing upon mild and moderate problems where the minister was often able to provide the needed help; (4) a growing awareness of the minister's great potential for preventive action through carefully planned programs of (a) premarital counseling, (b) counseling with young people facing vocational choices, (c) classes and counseling on marital problems with young married couples and others; (5) increased communication and cooperative efforts between physicians and ministers.

In spite of many overt signs of success in our day-by-day work, we felt a need for and conducted rigorous evaluation studies. We consider the criteria of success to lie in determining whether: (1) the ministers have incorporated concepts, approaches, and technics which make them better able to identify and manage effectively the problems brought to them by troubled people; (2) they are recognized by a large segment of the lay population as being interested in and available to help with the normal range of human problems, and can intelligently assist them in finding appropriate professional help when required; and (3) they as a professional group become more sensitized to the prevalence of unmet human needs in the community and become more active in efforts to provide needed services. Our evaluation studies will help us to know where we have succeeded; where we have failed; and most importantly, where changes of method and emphasis are needed.

Implications for Public Health

The clinics, the hospitals, and all the mental health personnel are unable to deal with more than a small fraction of those troubled people we call emotionally or mentally ill. It will take a small army of alert, interested, and trained professional people from many disciplines to identify and help the neglected, treat those who are developing more severe disturbances, and prevent the occurrence of illness and failure. This, in our opinion, is a public health responsibility in the same sense that any plague is a public health responsibility. Our methods and approach, at least in principle, offer one means whereby this mobilization of resources can be accomplished. When

health department personnel are ready to undertake the large-scale efforts that must come, they will find the clergy to be a most interested and highly motivated group.

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Analytical Methods Evaluation Service

Methods of air analysis are basic tools for studying air pollution processes and effects, for monitoring the present degrees of pollution, for setting air standards, and for evaluating control methods. Collaborative testing of proposed procedures has been recognized as an essential final step before their acceptance as standard methods.

In order to provide a continuing staff and facilities for the effective support of this important work, the Division of Air Pollution, PHS, established on July 1, 1966, the Analytical Methods Evaluation Service. Objectives of this service include: (a) the development of technology for the collaborative testing of methods of air sampling and analysis; (b) the application of identical sampling and analytical methodology by a group of collaborating laboratories using identical methods of gaseous or aerosol sample preparation to establish the reproducibility of a published method in the hands of different chemists in different laboratories; and (c) the optimization of these sampling and analytical methods before or after their collaborative testing, including the minimizing of the effects of interfering substances.

The Analytical Methods Evaluation Service will work in close cooperation with the Intersociety Committee on Manual of Methods for Ambient Air Sampling and Analysis, and will give first priority to testing its methods. This committee represents seven national professional societies: Air Pollution Control Association; American Conference of Governmental Industrial Hygienists; American Industrial Hygiene Association; American Public Health Association; American Society for Testing and Materials; American Society of Mechanical Engineers; and the Association of Official Analytical Chemists.